		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028522

Facility Name: The Carle Arbours

Address: 302 West Burwash (Number) Savoy (City) 61874 (Zip Code)

County: Champaign

Telephone Number: 217-383-3098 **Fax #** 217-383-3194

HFS ID Number: 371155535001

Date of Initial License for Current Owners: 02/01/84

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kerry G. Frerichs **Telephone Number:** 217-383-4784

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/04 to 06/30/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Tom Mullins
(Title) ADMINISTRATOR

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/04 Ending: 06/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	231	Skilled (SNF)	231	84,315	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,315	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,604	705	8,955	13,264	8
9	SNF/PED					9
10	ICF	20,222	27,745		47,967	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,826	28,450	8,955	61,231	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.62%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/84

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/84 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 53 and days of care provided 8,955

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/05 Fiscal Year: 06/30/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number The Carle Arbours # 0028522 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	438,527	42,754	160	481,441		481,441	(4,501)	476,940			1
2	Food Purchase		368,625		368,625		368,625		368,625			2
3	Housekeeping	194,872	33,725		228,597		228,597		228,597			3
4	Laundry	75,815	10,244	14,630	100,689		100,689		100,689			4
5	Heat and Other Utilities			206,703	206,703	(11,443)	195,260		195,260			5
6	Maintenance	52,423	43,079	65,980	161,482	(20,033)	141,449		141,449			6
7	Other (specify):* Waste/security					39,816	39,816		39,816			7
8	**TOTAL General Services**	761,637	498,427	287,473	1,547,537	8,340	1,555,877	(4,501)	1,551,376			8
	B. Health Care and Programs											
9	Medical Director			7,645	7,645		7,645		7,645			9
10	Nursing and Medical Records	2,696,187	271,967	955,442	3,923,596	51,975	3,975,571	(2,432)	3,973,139			10
10a	Therapy	47,760	2,679	1,025,774	1,076,213	(8,175)	1,068,038		1,068,038			10a
11	Activities	109,768	8,158	2,263	120,189		120,189	(7,075)	113,114			11
12	Social Services	120,425			120,425		120,425		120,425			12
13	CNA Training											13
14	Program Transportation			6,239	6,239	2,552	8,791		8,791			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,974,140	282,804	1,997,363	5,254,307	46,352	5,300,659	(9,507)	5,291,152			16
	C. General Administration											
17	Administrative			319,721	319,721		319,721	729,716	1,049,437			17
18	Directors Fees											18
19	Professional Services			256,986	256,986		256,986	(256,700)	286			19
20	Dues, Fees, Subscriptions & Promotions			71,671	71,671	2,268	73,939	(51,982)	21,957			20
21	Clerical & General Office Expenses	239,571	26,351	217,994	483,916	(52,019)	431,897	(98,264)	333,633			21
22	Employee Benefits & Payroll Taxes			1,111,306	1,111,306		1,111,306		1,111,306			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,404	13,404	(2,552)	10,852	(6,665)	4,187			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			153,520	153,520		153,520		153,520			26
27	Other (specify):*											27
28	**TOTAL General Administration**	239,571	26,351	2,144,602	2,410,524	(52,303)	2,358,221	316,105	2,674,326			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,975,348	807,582	4,429,438	9,212,368	2,389	9,214,757	302,097	9,516,854			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The Carle Arbours #0028522 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			403,676	403,676		403,676	(5,543)	398,133			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			525,421	525,421		525,421	(1,686)	523,735			32
33	Real Estate Taxes			37,500	37,500		37,500	(37,500)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,159	7,159	(121)	7,038		7,038			35
36	Other (specify):*							32,079	32,079			36
37	**TOTAL Ownership**			973,756	973,756	(121)	973,635	(12,650)	960,985			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,071,169		1,071,169		1,071,169	307,076	1,378,245			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			128,268	128,268	(2,268)	126,000		126,000			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		1,071,169	128,268	1,199,437	(2,268)	1,197,169	307,076	1,504,245			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,975,348	1,878,751	5,531,462	11,385,561		11,385,561	596,523	11,982,084			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/04 Ending: 06/30/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,501)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,686)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,392)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(5,543)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,408)	21		17
18	Fines and Penalties				18
19	Entertainment	(35)	11		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(15,320)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(96,856)	21		24
25	Fund Raising, Advertising and Promotional	(51,943)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(37,500)	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(13,784)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (230,968)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	827,491		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 827,491		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 596,523		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

The Carle Arbours

ID# **0028522**

Report Period Beginning: **07/01/04**

Ending: **06/30/05**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BEAUTY & BARBERSHOP	$ (475)	11	1
2	ACTIVITY INCOME	(6,565)	11	2
3	UNALLOWABLE NURSING	(40)	10	3
4	NON-DIRECT CARE TRAVEL	(6,665)	24	4
5	NON-REIMBURSABLE EXP	(39)	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(13,784)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number The Carle Arbours **#** 0028522 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(4,501)	0	0	0	0	0	0	0	0	0	0	(4,501)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,501)	0	0	0	0	0	0	0	0	0	0	(4,501)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,432)	0	0	0	0	0	0	0	0	0	0	(2,432)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(7,075)	0	0	0	0	0	0	0	0	0	0	(7,075)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(9,507)	0	0	0	0	0	0	0	0	0	0	(9,507)	16
	C. General Administration													
17	Administrative	0	729,716	0	0	0	0	0	0	0	0	0	729,716	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(15,320)	(241,380)	0	0	0	0	0	0	0	0	0	(256,700)	19
20	Fees, Subscriptions & Promotions	(51,982)	0	0	0	0	0	0	0	0	0	0	(51,982)	20
21	Clerical & General Office Expenses	(98,264)	0	0	0	0	0	0	0	0	0	0	(98,264)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(6,665)	0	0	0	0	0	0	0	0	0	0	(6,665)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(172,231)	488,336	0	0	0	0	0	0	0	0	0	316,105	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(186,239)	488,336	0	0	0	0	0	0	0	0	0	302,097	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **The Carle Arbours** **#** **0028522** **Report Period Beginning:** **07/01/04** **Ending:** **06/30/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(5,543)	0	0	0	0	0	0	0	0	0	0	(5,543)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,686)	0	0	0	0	0	0	0	0	0	0	(1,686)	32
33	Real Estate Taxes	(37,500)	0	0	0	0	0	0	0	0	0	0	(37,500)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	32,079	0	0	0	0	0	0	0	0	0	32,079	36
37	**TOTAL Ownership**	(44,729)	32,079	0	0	0	0	0	0	0	0	0	(12,650)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	307,076	0	0	0	0	0	0	0	0	0	307,076	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	307,076	0	0	0	0	0	0	0	0	0	307,076	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(230,968)	827,491	0	0	0	0	0	0	0	0	0	596,523	45

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/04 Ending: 06/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
The Carle Foundation	100			Carle Hospital	Urbana	Hospital/DME/Rx
				Carle HealthCare	Urbana	Ambulance

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Home Office-Administrative	$	Carle Foundation	100.00%	$ 170,695	$ 170,695	1
2	V	36	Home Office-Loss/Gain on Disp		Carle Foundation	100.00%	1,568	1,568	2
3	V	17	Shared A & G Hosp Gen. Svcs		Carle Foundation	100.00%	559,021	559,021	3
4	V	36	Shared A & G Hosp Capital		Carle Foundation	100.00%	30,511	30,511	4
5	V	19	Management Fees	241,380	Carle Foundation	100.00%		(241,380)	5
6	V	39	Pharmacy & Drugs	930,533	Carle Foundation	100.00%	1,237,609	307,076	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,171,913			$ 1,999,404	$ * 827,491	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/04 Ending: 06/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/04 Ending: 06/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: The Carle Foundation
Street Address: 611 W. Park St.
City / State / Zip Code: Urbana, IL 61801
Phone Number: (217-383-4784
Fax Number: (217-383-4588

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Home Office-Administrative	Direct Costs	12	12	$ 170,695	$ 99,247	12	$ 170,695	1
2	36	Home Office-Loss/Gain on Disp	Direct Costs	12	12	1,568		12	1,568	2
3	17	Shared A & G Hosp Gen. Svcs	Direct Costs	12	12	559,021	339,270	12	559,021	3
4	36	Shared A & G Hosp Capital	Direct Costs	12	12	30,511		12	30,511	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 761,795	$ 438,517		$ 761,795	25

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/04 Ending: 06/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	$26.00 Million Bond Issue	x		Refinance/Remodel	N/A	06/01/96	$ 1,086,927	$ 15,927	Multiple	Variable	$ 21,726	1
2	$49.99 Million Bond Issue	x		Refin/Remod/Arbrs Ct	N/A	05/01/98	6,967,497	2,904,461	Multiple	Variable	210,458	2
3	$29.30 Million Bond Issue	x		Refinance/Remodel	N/A	07/01/99	253,671	226,832	Multiple	Variable	5,558	3
4	$190.3 Million Bond Issue	x		Refinance	N/A	11/10/04	5,741,801	5,702,422	Multiple	Variable	81,083	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 14,049,896	$ 8,849,642			$ 318,825	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 14,049,896	$ 8,849,642			$ 318,825	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number The Carle Arbours **#** 0028522 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	37,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	37,500	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	8
	2001	9
	2002	10
	2003	11
	2004	12

This is the first year for a real estate tax accrual. It is management's estimate of one half a year's (first half of calander year 2005) tax bill which will be assessed in 2006. NO real estate taxes have been paid.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Carle Arbours COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0028522

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/04 Ending: 06/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 69,118 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	174,240	1984	$ 274,934	1
2					2
3	TOTALS	174,240		$ 274,934	3

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	231		1984	1973	$ 2,967,466	$ 84,785	35	$ 84,785	$	$ 1,815,807	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	RENOVATIONS			1984	267,128	9,152	VARIOUS	9,152		230,589	9
10	WINDOWS			1984	6,326		VARIOUS			6,326	10
11	SIGNS & A/C			1984	15,232		15			15,232	11
12	LANDSCAPING			1985	13,589		VARIOUS			13,589	12
13	PLUMBING			1985	34,747	1,390	VARIOUS	1,390		28,122	13
14	ROOF & ELECTRICAL			1985	23,658	239	VARIOUS	239		22,580	14
15	KITCHEN REMODEL			1985	23,504	688	VARIOUS	688		20,426	15
16	LANDSCAPING			1986	7,325		VARIOUS			7,325	16
17	RENOVATIONS			1986	31,097	786	VARIOUS	786		26,577	17
18	LANDSCAPING			1987	2,032		15			2,032	18
19	ROOF REPAIR			1987	749		15			749	19
20	CARPET			1987	6,689		15			6,689	20
21	RENOVATIONS			1987	28,041		15			28,041	21
22	CARPET & FLOORING			1988	21,483		15			21,483	22
23	ALZHEIMERS ADDITION			1988	1,400	47	VARIOUS	47		797	23
24	GENERATOR			1988	11,693	275	VARIOUS	275		10,845	24
25	INSULATION			1988	3,650	183	20	183		3,118	25
26	RENOVATIONS			1988	6,774	8	VARIOUS	8		6,673	26
27	ALZHEIMERS/2ND FLOOR RENOVATION			1990	6,214	251	VARIOUS	251		4,764	27
28	EMERGENCY POWER DISTRIBUTION			1990	27,115	1,334	VARIOUS	1,334		20,131	28
29	DOORS			1990	1,388	62	15	62		1,388	29
30	REMODELING			1990	2,838	142	20	142		2,081	30
31	REMODELING			1991	472,549	20,391	VARIOUS	20,391		287,721	31
32	FLOORING			1991	87,008	2,547	VARIOUS	2,547		70,663	32
33	RENOVATIONS			1991	1,981	49	VARIOUS	49		1,670	33
34	RENOVATIONS			1992	5,150	343	15	343		4,449	34
35	ROOF REPAIR			1992	22,257		10			22,257	35
36	FLOORING			1992	14,427	702	VARIOIS	702		12,789	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LANDSCAPING	1992	$ 4,734	$	10	$	$	$ 4,734	37
38	OUTDOOR LIGHTING	1993	8,352	557	15	557		6,774	38
39	ELEVATOR	1993	10,788	561	VARIOUS	561		6,839	39
40	REMODELING	1993	48,830	2,384	VARIOUS	2,384		29,020	40
41	PARKING LOT IMPROVEMENTS	1994	4,300		10			4,300	41
42	ELEVATOR	1994	3,368	168	20	168		1,937	42
43	RENOVATIONS	1994	57,905	2,739	VARIOUS	2,739		34,971	43
44	PARKING LOT IMPROVEMENTS	1995	11,934	973	VARIOUS	973		11,527	44
45	REMODELING	1994	55,764	2,839	20	2,839		30,308	45
46	DOORS	1994	4,684	207	VARIOUS	207		2,924	46
47	REMODELING	1995	2,320	116	20	116		1,189	47
48	REMODELING	1995	12,720	669	19	669		6,750	48
49	ROOF REPAIRS	1995	20,660	1,054	VARIOUS	1,054		10,733	49
50	ROOF AIR CONDITIONER	1995	40,354	3,558	VARIOUS	3,558		34,551	50
51	ROOF AIR CONDITIONER	1995	2,950	295	10	295		2,778	51
52	RENOVATIONS - KITCHEN/DINING	1995	264,018	14,668	18	14,668		141,788	52
53	RENOVATIONS - KITCHEN/DINING	1996	5,613	312	18	312		2,884	53
54	RENOVATIONS - BATHROOM	1996	79,899	3,995	20	3,995		36,620	54
55	FLOORING	1996	15,511	1,551	10	1,551		14,089	55
56	WINDOWS	1996	3,028	151	20	151		1,325	56
57	ENTRANCE CANOPY	1996	1,580	158	10	158		1,369	57
58	ELECTRIC DOORS	1996	5,072	437	VARIOUS	437		3,784	58
59	ROOFING	1996	22,900	2,290	10	2,290		19,847	59
60	REPAIR BOILER ROOM	1996	3,300	330	10	330		2,860	60
61	REFURBISH SIGN	1996	1,200	120	10	120		1,040	61
62	ENTRANCE CANOPY	1997	3,693	369	10	369		3,108	62
63	NURSE STATIONS	1997	34,011	2,126	VARIOUS	2,126		16,132	63
64	FENCE	1998	3,885	259	15	259		1,878	64
65	DOORS	1998	945	63	15	63		420	65
66	NURSE STATIONS	1998	10,000	667	15	667		4,446	66
67	CHAIN LINK FENCE	1998	4,544	303	15	303		2,045	67
68	BATHS	1999	623,243	31,162	20	31,162		194,584	68
69	WALL ARCHITECTURAL	1999	1,491	75	20	75		453	69
70	TOTAL (lines 4 thru 69)		$ 5,487,106	$ 198,530		$ 198,530	$	$ 3,332,920	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,487,106	$ 198,530		$ 198,530	$	$ 3,332,920	1
2	SUBACUTE IMPROVEMENTS	2000	75,624	4,020	VARIOUS	4,020		21,774	2
3	RENOVATIONS- BATHROOMS	2000	36,055	1,898	19	1,898		10,279	3
4	HANDRAILS	2000	11,693	779	15	779		4,222	4
5	HALL FLOOR	2000	30,472	1,604	19	1,604		8,687	5
6	ROOF REPAIRS	2000	7,800	433	18	433		2,131	6
7	AIR CURTAIN	2000	1,110	62	18	62		303	7
8	BATH RENOVATION	2000	2,438	128	19	128		631	8
9	SECOND FLOOR AIR	2000	4,829	268	18	268		1,230	9
10	FACILITY IMPROVEMENTS	2001	274	55	5	55		224	10
11	THERAPY FLOOR	2001	3,700	370	10	370		1,449	11
12	THERAPY CEILING	2001	3,194	639	5	639		2,502	12
13	FIRST FLOOR HANDRAILS	2001	12,480	2,496	5	2,496		8,944	13
14	SECOND FLOOR AIR	2002	86,210	5,129	VARIOUS	5,129		16,033	14
15	WALL ARCHITECHURAL	2002	7,032	414	17	414		1,448	15
16	GIFT SHOP EXPANSION	2002	16,819	1,066	VARIOUS	1,066		3,687	16
17	CARPET	2002	3,984	797	5	797		2,656	17
18	THERAPY FLOOR	2002	180	18	10	18		59	18
19	VINYL FLOORING	2002	5,979	598	10	598		1,844	19
20	THERAPY CEILING	2002	6,930	1,386	5	1,386		4,274	20
21	NURSE STATIONS(PER FY99 IPA AUDIT)	1995	69,094	3,839	VARIOUS	3,839		37,746	21
22	RENOVATIONS-FIRE WALL	2003	146,487	6,972	VARIOUS	6,972		19,433	22
23	ARBRS COURT BUILDING	2003	1,397,938	34,948	VARIOUS	34,948		72,809	23
24	RENOVATIONS-NURSING STATION/TEMP CONTROLLERS	2003	57,666	1,442	VARIOUS	1,442		3,003	24
25	FLOORING	2003	7,490	1,098	VARIOUS	1,098		3,003	25
26	ARBRS COURT BUILDING	2004	344,851	8,764	40	8,764		15,209	26
27	FENCING	2004	7,172	429	VARIOUS	429		703	27
28	LANDSCAPING	2004	80,580	15,173	VARIOUS	15,173		23,993	28
29	ORIG BLDG RENOVATIONS	2004	83,766	5,924	VARIOUS	5,924		7,167	29
30	RENOVATIONS	2004	74,853	1,879	VARIOUS	1,879		3,287	30
31	SINAGE	2004	6,427	1,229	VARIOUS	1,229		2,150	31
32	2ND FLR INTERIOR UPGRADE	2005	87,775	2,926	VARIOUS	2,926		2,926	32
33	EXTERIOR PAINTING & REPAIRS	2005	71,086	2,560	VARIOUS	2,560		2,560	33
34	TOTAL (lines 1 thru 33)		$ 8,239,094	$ 307,873		$ 307,873	$	$ 3,619,286	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 8,239,094	$ 307,873		$ 307,873	$	$ 3,619,286	1
2	SIGNS	2005	2,040	102	10	102		102	2
3	CAPITALIZED INTEREST	2004	56,570	1,355	40	1,355		1,355	3
4	rounding		(2)						4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,297,702	$ 309,330		$ 309,330	$	$ 3,620,743	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,688,655	$ 83,747	$ 83,747	$		$ 1,280,849	71
72	Current Year Purchases	34,220	1,968	1,968			1,968	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,722,875	$ 85,715	$ 85,715	$		$ 1,282,817	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	MEDIVAN TRANSPORT		2005	$ 29,644	$ 3,088	$ 3,088	$	4	$ 29,644	76
77	CARGO TRANSPORT	1999 FORD VAN	2005	28,749				4	28,749	77
78										78
79										79
80	TOTALS			$ 58,393	$ 3,088	$ 3,088	$		$ 58,393	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,353,904	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 398,133	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 398,133	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,961,953	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	NURSE STATIONS-1997&1998	$ 49,545	$ 3,078	$ 23,344	86
87	BATHS-1999	9,818	491	3,068	87
88	NURSING HOME FINDERS FEE-1984	38,500	1,540	32,982	88
89	PROJECT 95-028-00-1997	6,940	434	3,290	89
90	EQUIP-BEDS-1983	1,690		1,690	90
91	TOTALS	$ 106,493	$ 5,543	$ 64,374	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/04 Ending: 06/30/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 7,038 Description: Special beds - $4,475, scales - $650, Passive motion devices - $666, CPM - $885, other -$362
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	Ln 10a Col 3	hrs	$	n/a	$ 478,220	$	n/a	$ 478,220	1
2	Licensed Speech and Language Development Therapist	Ln 10a Col 3	hrs		n/a	87,994		n/a	87,994	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 10a Col3	hrs		n/a	458,114		n/a	458,114	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 1,024,328	$		$ 1,024,328	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number The Carle Arbours **#** 0028522 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 189,699	$	1
2	Cash-Patient Deposits	21,869		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,515,803		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	769,912		5
6	Prepaid Insurance	48,343		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(5,023,989)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (2,478,363)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (2,478,363)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 730,017	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 730,017	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 730,017	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,208,380)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (2,478,363)	$	48

***(See instructions.)**

Facility Name & ID Number The Carle Arbours **#** 0028522 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,046,278)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,046,278)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(197,803)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe) **PARTNERSHIP REVENUE**	35,701	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (162,102)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,208,380)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/04 Ending: 06/30/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,505,189	1
2	Discounts and Allowances for all Levels	(5,599,138)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,906,051	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,273,148	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,273,148	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	250	13
14	Non-Patient Meals	4,501	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	25,850	16
17	Sale of Drugs	967,085	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 997,686	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,686	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,686	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	ATTACHE SCH OF OTHER REVENUE	9,182	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,182	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,187,753	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,547,537	31
32	Health Care	5,254,307	32
33	General Administration	2,410,524	33
	B. Capital Expense		
34	Ownership	936,256	34
	C. Ancillary Expense		
35	Special Cost Centers	1,071,169	35
36	Provider Participation Fee	165,768	36
	D. Other Expenses (specify):		
37	ROUNDING	(5)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,385,556	40
41	**Income before Income Taxes (line 30 minus line 40)****	(197,803)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (197,803)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/04 Ending: 06/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,952	2,080	$ 66,222	$ 31.84	1
2	Assistant Director of Nursing	1,496	2,012	54,097	26.89	2
3	Registered Nurses	20,906	21,866	598,227	27.36	3
4	Licensed Practical Nurses	37,815	41,119	786,329	19.12	4
5	CNAs & Orderlies	92,330	101,452	1,131,688	11.15	5
6	CNA Trainees					6
7	Licensed Therapist	3,645	4,064	48,925	12.04	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,448	32,751	13.38	9
10	Activity Assistants	6,402	6,988	77,553	11.10	10
11	Social Service Workers	5,121	6,141	116,683	19.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,043	2,169	43,177	19.91	14
15	Cook Helpers/Assistants	35,984	37,040	398,739	10.77	15
16	Dishwashers					16
17	Maintenance Workers	4,714	5,235	52,641	10.06	17
18	Housekeepers	17,952	19,678	194,646	9.89	18
19	Laundry	7,227	8,581	78,200	9.11	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,266	1,354	28,304	20.90	22
23	Office Manager					23
24	Clerical	10,930	12,071	173,387	14.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,415	6,888	93,779	13.61	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	258,278	281,186	$ 3,975,348 *	$ 14.14	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	n/a	7,645	Ln 9 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 7,645		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,565	$ 75,203	Ln 10 Col 3	50
51	Licensed Practical Nurses	6,538	242,855	Ln 10 Col 3	51
52	Certified Nurse Assistants/Aides	24,766	589,786	Ln 10 Col 3	52
53	TOTAL (lines 50 - 52)	32,869	$ 907,844		53

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
J. SNIDER (7/04 - 11/04)	ADMINISTRATOR	0	$ 52,730
C. LOWNEY (12/04 - 3/05)	ADMINISTRATOR	0	29,434
T. MULLINS (4/05 - 6/05)	ADMINISTRATOR	0	17,830
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 99,994

B. Administrative - Other

Description	Amount
HERITAGE ENTERPRISES - MGMT CONSULTING SVC	$ 304,401
HARTWER, TURNER	15,320
TOTAL (agree to Schedule V, line 17, col. 3)	$ 319,721
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CARLE HOSPITAL	RELATED PARTY	$ 241,380
CARLE CLINIC ASSOC	DATA PROC	15,606
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 256,986

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 98,566
Unemployment Compensation Insurance	29,162
FICA Taxes	287,720
Employee Health Insurance	531,755
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE INSURANCE	4,674
LONG TERM DISABILITY	11,316
PENSION	135,806
TUITION REIMBURSEMENT	10,838
EMPLOYEE ACTIVITIES	1,469
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,111,306

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 6,968
Advertising: Employee Recruitment	2,880
Health Care Worker Background Check	
(Indicate # of checks performed)	
ADVERTISING	47,116
P/R & ENTERTAINMENT	2,346
IHCA DUES	11,530
OTHER DUES & FEES	579
Less: Public Relations Expense	(2,346)
Non-allowable advertising	(47,116)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,957

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,653
Seminar Expense	2,534
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,187

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number The Carle Arbours # 0028522 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $11,530**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? ____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? ____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **11.0**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **41,683** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. ____

(9) Are you presently operating under a sublease agreement? ____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **126,000**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **4,501**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ ____
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ ____

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **McGladery & Pullen** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. ____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.